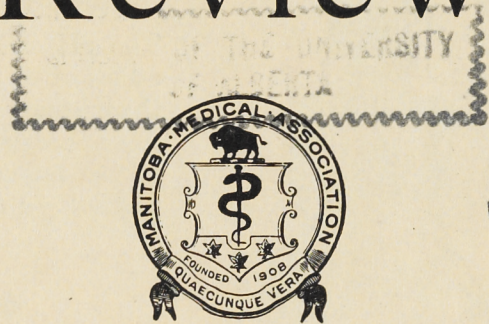


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# Manitoba Medical Review



STACKS

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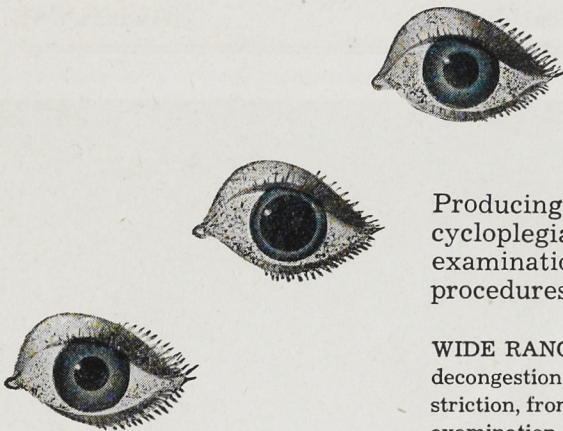
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## Cardiospasm

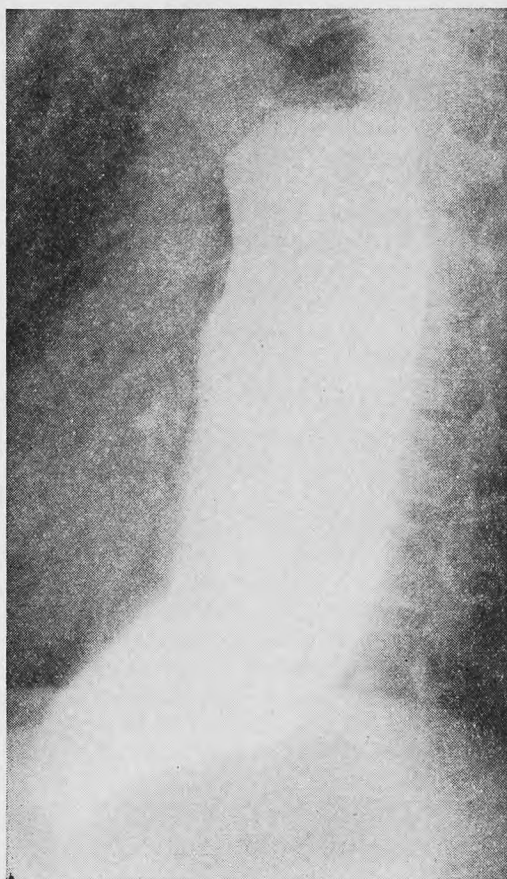
E. P. Angelle, M.D.

Cardiospasm is the term commonly applied to the condition variously referred to as mega-oesophagus, diffuse dilatation of the oesophagus, idiopathic dilatation of the oesophagus and achalasia of the cardia. The first two terms emphasise the gross appearance, the third suggests its unknown etiology and the fourth indicates a possible cause. None of these designations is satisfactory and "cardiospasm" is no better because many cases with dilatation present no evidence of spasm. The use of the term cardiospasm in this article is merely for convenience.

In discussing the etiology of cardiospasm some authors refer to pathological changes in the oesophagus (intrinsic causes) and in the gastro-intestinal or biliary tracts (extrinsic causes). In this paper we are considering the condition as it exists in the absence of demonstrable lesions. The possibility of these organic lesions, however, must be remembered, for otherwise serious diseases might be overlooked. The etiology of cardiospasm, where neither intrinsic nor extrinsic factors can be found, is not completely understood. There are, however, three authorities who advance plausible theories. First of these is Hurst, who is responsible for the name "achalasia". Achalasia means failure to relax and, according to Hurst, cardiospasm is "a condition in which, owing to pathological changes in Auerbach's plexus, the relaxation of the cardiac sphincter, which is normally the last stage in the act of deglutition, does not occur." Because the sphincter fails to relax the food cannot enter the stomach, but accumulates in the oesophagus which becomes progressively more dilated. Histological confirmation of this argument is given by Lendrum, who found the ganglion cells in the lower end of the oesophagus to be markedly reduced in number. According to Jackson the trouble lies in the "diaphragmatic pinchcock" by the action of which food is prevented from regurgitating. Failure of this function gives rise to the development of compensatory changes in the oesophagus and leads to achalasia. Knight, from his animal experiments, concludes that there exists a true sphincter in the oesophagus. Division of the vagi produced a spastic state in the lower end of the oesophagus. This could be abolished by sectioning the sympathetic nerves.

This is in keeping with the accepted actions of these nerves. It seems probable that the vagus carries both motor and inhibitory fibres to the

cardia and that stimulation of this nerve may be followed in some persons by relaxation of the orifice and in others by contraction. However, in cardiospasm it seems that stimulation of the vagus results in relaxation. On the other hand the sympathetic innervation, which also conveys both inhibitory and motor fibres, when stimulated will produce a spastic state in the lower portion of the oesophagus. From his experimental results



Knight was led to recommend gastric sympathectomy and performed the operation with successful results. In addition to these organic theories there is the belief held by many that the disorder is largely or altogether psychogenic in origin. It is quite likely that psychological factors initiate the process and its continuance leads to the changes in structure.



In frequency cardiospasm is second only to carcinoma of the oesophagus in the production of symptoms of oesophageal obstruction. It affects both sexes but is much more common in women "of the emotional type". Usually the onset is sudden. While eating the patient becomes conscious of the fact that her food has "stuck" and the point of sticking is felt to be at the lower end of the sternum. At first the attacks are intermittent. Later the trouble may occur at every meal for several days at a time. Still later it may be persistent. Bouts of dysphagia alternating with periods of comfortable swallowing should draw attention to cardiospasm as the responsible condition. True pain does not occur but the patient is conscious of an uncomfortable feeling of fullness and pressure. As the oesophagus stretches the uncomfortable feeling becomes less. Relief is obtained by regurgitation, it is not vomiting and is never accompanied by nausea.

When the condition persists every meal may be held in the oesophagus with only a trickle of food getting through. Under these circumstances the patient will become very thin and may have so little residue that defecation may occur at intervals of even weeks. In spite, however, of the small food intake the patient is able to maintain sufficient strength to carry on her duties. Long established cases after eating will deliberately regurgitate the greater part of what they have eaten. Constant and progressive dilatation of the oesophagus leads to inflammatory changes in the tube itself and also to symptoms, especially pulmonary, from pressure.

If the attacks are at long intervals their nature is likely to be overlooked. If they are more frequent dyspepsia is likely to be the diagnosis. More serious is the diagnosis of cardiospasm when in fact the symptoms are due to fibrous stricture or cancer. The gradual onset of dysphagia, its steady increase and the presence of pain are all evidence that the disorder is **not** cardiospasm.

All patients suffering from continued difficulty in swallowing should be X-rayed. The picture in cardiospasm is characteristic. As the presence of food in the oesophagus may interfere with the shadow radiography should be preceded by washing out the structure. As the barium shadow is watched it will be seen to stop at the lower end of the oesophagus and to remain until a column of sufficient height has been accumulated to give the weight necessary to pass into the stomach. The degree of dilatation present depends upon the duration of the condition but in chronic cases it may be enormous. Not only is the oesophagus dilated but it is also twisted and elongated. The end of the barium shadow is in the form of a blunt point. As the height of the barium is raised a little will trickle through a narrow lumen

into the stomach, the trickle ceasing as soon as the "critical level" is again reached by the column. This appearance is peculiar to cardiospasm and is quite different from the appearance seen in cancer or oesophageal ulcer. Oesophagoscopy, which gives a direct view of the passage, is also a valuable diagnostic measure.

The treatment advised depends largely upon the view held as to the cause. There is probably a psychogenic factor in every case and this should be investigated. Attention to diet may give freedom from attacks. The food should be taken in small amounts, chewed thoroughly and, on the whole, be smooth and soft in nature. Some authors advise the use of a little mineral oil before eating. Meals should be small and frequent. In advanced cases very large meals may have to be taken in order to get a sufficient head of pressure to force a little past the obstruction.

When the condition has reached a greater degree those who follow the achalasia theory of Hurst will employ the method of treatment advocated by that authority. Hurst uses rubber bougies of various guage, each of which contains 21 ounces of mercury. Beginning with guage 28 larger bougies are passed until guage 34 is reached and the treatment repeated four times daily. After the bougie has been in position for fifteen minutes it is removed and a glass of milk is taken. The patient is taught how to pass the bougies and may find it necessary to precede the heavier meals of the day with such treatment.

A modification of the mercury bougie technique is the use of a Mosher bag after the largest bougie has been passed. The bag may be swallowed or, if swallowing is difficult, it can be introduced through an oesophagoscope. When in place the bag is inflated to a tension of four pounds and left in place for about five minutes. Another method of dilatation is the passage of graduated sounds over a previously swallowed silk thread. Russel has devised a hydrostatic dilator.

These measures are usually successful but there are instances where the oesophagus is so dilated and distorted that more drastic treatment is necessary. Surgical measures are then indicated but this is seldom. At the Mayo Clinic out of 1,200 cases only 7 required operation. The objects of surgical interference are: to give relief when stretching has failed, to avoid the necessity of continual stretching, and to remove the cause of the disability. The methods are: (1) the freeing of the cardia and lower oesophagus combined with mechanical dilatation from above; (2) manual dilatation through gastrostomy; and (3) transperitoneal oesophago-gastrostomy. The results of operation are very gratifying. Symptomatic relief is dramatic. The patient rapidly regains lost weight and improves in spirits. Subsequent roentgeno-



grams may, however, show that the "cardiospasm" still persists so that the patient's cure in these cases is principally symptomatic. When a diverticulum has formed it should be remedied surgically by anastomosis with the stomach. A variety of plastic operations similar to those of Finney and Rammstedt have been described. Craig, Moersch and Vinson report resection of the cervico-thoracic trunk in a case where previous treatment had failed. Preliminary tests had indicated that complete relief was likely to follow sympathectomy. A bilateral operation was done so that the resulting phenomena (Horner's syndrome, temperature of face and arms, etc.) would be the same on both sides and also more thoroughly to denervate the oesophagus. The operation was completely successful. The results following coeliac sympathectomy, however, have not been satisfactory. Considering the extensive and serious procedures necessary in any form of surgical attack it is fortunate that surgery is very seldom indicated.

In most cases the condition is mild and tolerable. Spontaneous cure never occurs but the simpler methods of treatment are usually sufficient to keep the patient comfortable and in a state of good nutrition. Drugs play a very minor role in treatment. The sedatives are useful because they lessen the emotional tone, make the patient less easily excited and diminish the

anxiety which is always present. Members of the belladonna group are now regarded as being useless.

On May 15, 1945, Mr. E. W., age 42, reported, complaining of difficulty in swallowing and regurgitation of food that he had ingested the day before. Swallowing was accompanied by retrosternal pain. There had been vague dyspepsia for over 20 years but in the past six months the attacks of dysphagia had been coming on more often. These attacks used to be of very short duration but the present attack had lasted for several days and that was the reason he was consulting the doctor.

The history was otherwise irrelevant. Physical examination was essentially negative. The patient was nervous. Urinalysis and blood count, normal; W.R. negative.

He was given a barium drink, and Fig. 1 shows the typical roentgenologic evidence of cardiospasm.

He reported back for gastric analysis which was negative and after passing the Levene tube he claimed he was completely relieved.

He called a month later to say that he had not had any further attacks. The symptoms in this case have not caused very much discomfort to the patient, but one expects that he will have recurrences of difficulty in swallowing. He was advised to return for dilation of the cardia.

## Food Allergy

C. H. A. Walton, M.Sc., M.D., F.A.C.P.

Allergy to food is probably common. It has been observed and described under various names for centuries, but it is only in the past thirty-three years that the concept of allergy to food was developed and placed on a scientific basis.

In general clinical food allergy occurs most commonly in children. Allergic manifestations in infants and pre-school children are most frequently due to foods. As the child grows older, inhalants begin to play a part and these tend to supersede the food sensitivities. This applies particularly to respiratory allergy. However, food sensitivity does persist in many adults, especially in such conditions as urticaria, migraine, gastro-intestinal allergy, etcetera. Food allergy is to be distinguished from certain food intolerances or idiosyncracies. Certain foods, because of their chemical makeup, may cause undesirable symptoms which act pharmacologically rather than allergically. The common intolerance of many people to cabbage, onion, radish, cucumber, eggs, etcetera, is an example.

Food allergy may manifest itself in any type of allergic reaction. As mentioned above, it

accounts for almost all the allergic reactions in infancy and throughout life it is the chief cause of urticaria and migraine. Food reactions are generally characterized by a reaction, time varying from one-half to twenty-four hours in contrast to the immediate reaction to inhalants. Food allergic symptoms may occur acutely at long intervals when due to rarely eaten or seasonal foods. Chronic food allergy, of course, occurs when the food allergen is a common one in the diet. Duration of symptoms may vary from half an hour to several days and up to two weeks.

The most common syndromes produced by food allergy are gastro-intestinal disorders involving abdominal discomfort, spastic constipation, recurring diarrhoea, gaseous distension, pruritis ani, etcetera, urticaria, angioneurotic oedema, atopic dermatitis, headache, rhinitis and asthma.

Food allergens reach the tissues by direct contact, ingestion with subsequent absorption and by inhalation, as in the case of flour and odours or vapors of cooking foods. They may also reach the infant patient by breast milk.

The quantity and quality of the allergic food determine not only the severity but the occur-

\* Fifth in a series of short articles on Allergy. From the Department of Medicine, University of Manitoba.



rence of symptoms. Symptoms may occur only when large amounts of the particular food are taken. It is also known that length of time of storage and cooking influence the reactions very materially. Individual tolerance to a given allergenic food varies from time to time and also with such circumstances as the effects of other foods, condition of the intestinal tract or infection. Fatigue, emotional upsets and excitement may be very important secondary factors.

The foods which most commonly are found to be responsible for food allergy are:

1. Cereals: Particularly wheat and oats.
2. Egg: Sensitivity to the white part of hen's eggs is very common. It is probable that egg yolk rarely causes a true allergic reaction.
3. Milk: Milk is also a common allergenic food, and the lactalbumin fraction seems most important.
4. Meat sensitivity is less common. Pork and chicken are the worst offenders.
5. Fish in one of its many forms is not an infrequent cause and of course fish products such as fish glue and caviar are included. Fish reactions are apt to be very severe.
6. Vegetables when raw are more prone to cause trouble. The more frequent offenders are beans, peas (including peanuts), potato, tomato and onion.
7. Fruits are frequent causes of acute seasonal urticaria but may also cause chronic symptoms, especially the citrous fruits, banana and apple.
8. Nuts are not infrequent offenders and may

produce very severe symptoms, especially urticaria and asthma.

9. Beverages: Coffee and tea are uncommon food allergens, but cocoa (including chocolate) is a most important one.

### Diagnosis

Diagnosis of food allergy is often difficult. Food must always be considered in all allergic problems. A knowledge of its characteristics and a very careful history may suggest a diagnosis. Skin tests are sometimes helpful when suitable test extracts are used, especially by the intradermal technique. However, skin tests may be disappointing. There are many technical reasons for this and perhaps the most important is that food is greatly changed by cooking and digestion. Extraction methods are as yet not entirely satisfactory. A negative skin test does not rule out a suspected food allergy and a positive reaction is of no importance unless confirmed by clinical trial. Further skin tests may be dangerous with severe sensitivities, especially with fish, nuts and egg.

Elimination diets are very useful and should be used often but it is important to emphasize that such diets are only for diagnosis and should not be persisted in for more than two or three weeks for fear of serious dietary deficiencies. This is a special danger in childhood.

The use of food diaries is an exceedingly helpful measure if the patient is intelligent and co-operative. A daily record of all foods eaten and of symptoms will frequently give invaluable information.

## Cholecystography

The Last in a Series of Articles on Radiology — H. M. Edmison, M.D.

During the last twenty years gall bladder visualization has gradually become a most important method of investigation and yet the full significance of the examination is not always appreciated. For this reason it was thought that a brief discussion of the subject might be useful.

The "dye" may be given either by mouth or intravenously, but the oral method is much more commonly used at the present time. The drug or "dye" in tablet form now used in many laboratories has been a very definite improvement in both patient tolerance and in accuracy of diagnosis.

The following method has become standardized universally with only a few minor variations in the quantity and frequency of the dose. The dye is ingested after a light, fat-free evening meal and no further food is allowed until the first part of the examination has been completed the following morning. Fluids can be taken freely.

Films are made about fifteen and seventeen hours after the dye has been taken, and if the gall bladder visualizes satisfactorily a fatty meal is given. This should cause the normal gall bladder to contract.

The importance of satisfactory radiographic technique cannot be stressed too strongly, for films of poor quality will reduce the accuracy of the test considerably.

### Visualization

Normally the dye passes from the stomach to the small intestine, from which it is absorbed into the blood stream. It is then excreted with the bile but in a dilute form, not sufficiently dense to be demonstrated by X-ray. The dye, along with the bile, enters the gall bladder, which concentrates it by extracting the water, and only then is it dense enough to produce a shadow on the X-ray film.

The normal gall bladder should contract and empty partly or completely when adequate stimulus is applied.

The ability of the gall bladder to concentrate the dye, and incidentally visualize, is dependent on a healthy mucosa. However, slight changes, such as mild inflammation or cholesterol deposits (strawberry gall bladder), may not affect the visualization and these are responsible for a certain margin of error. On the other hand, more advanced changes in the mucosa resulting from inflammation will prevent concentration and the gall bladder will not visualize.

Occasionally the gall bladder is only faintly visualized, but the great majority of these will show a completely satisfactory shadow if a second dose of dye is given and the examination repeated the following day. This is usually considered the result of incomplete absorption from the intestinal tract but an explanation is not always possible.

Irregularities in the shape of the shadow are rarely the result of pericholic adhesions, but are much more likely to be due to the gall bladder folding over the edge of the liver or pressure from adjacent bowel, especially the duodenum.

#### Non-Visualization

When the gall bladder does not visualize, the possibility of errors in technique must first be carefully considered. Patients do not always follow instructions exactly, no matter how carefully given, and on occasion have neglected to take the dye altogether. The premature ingestion of food may cause the organ to contract and empty before films are made.

As the position of the gall bladder varies widely, all possible locations must be included before examination can be considered adequate.

The gall bladder will not visualize in the presence of pyloric or duodenal obstruction with gastric retention, as the dye will remain in the stomach and cannot be absorbed. As the dye must reach the gall bladder by first passing through the liver, obstructive jaundice or any advanced degenerative condition of the liver will prevent visualization.

In most cases of non-visualization, however, disease of the gall bladder is directly responsible. The mucosa may be destroyed by chronic inflammation and is no longer able to function, the cystic duct may be obstructed by a calculus or the gall bladder may be filled with inspissated bile.

#### Gall Stones

A certain number of gall stones (25%) contain sufficient calcium so that they may be demonstrated radiographically. The shadows of these are usually quite typical and whether the gall

bladder visualizes or not, there is rarely any doubt regarding the diagnosis.

The majority of biliary calculi, however, are not opaque to X-rays and radiologists are not infrequently asked why stones were not reported in a certain case when any number of them were found at operation. The explanation, of course, is that non-opaque stones will not be seen unless the gall bladder visualizes and then they can be outlined only by contrast with opaque dye. If the gall bladder does not visualize, non-opaque stones will not be detected.

The presence of gas in the bowel can be most confusing and may lead to errors in interpretation. It will sometimes tax the skill of the expert technician to obtain a view of the gall bladder which is free from gas shadow.

#### Contraction

The gall bladder empties by contraction of the musculature and relaxation of the sphincter of Oddi. Persistent failure to contract may be due to thickening of the wall, but we have seen a number of cases with a clinical diagnosis of achalasia of the sphincter in which there has been little if any contraction after adequate stimulus.

Small cholesterol stones are occasionally seen in a partly emptied gall bladder which were obscured by the dense shadow of the dye before contraction.

#### Accuracy

The following figures are based on the results of examinations done by some of the most capable men in the field of radiology, on a large number of cases checked by operation.

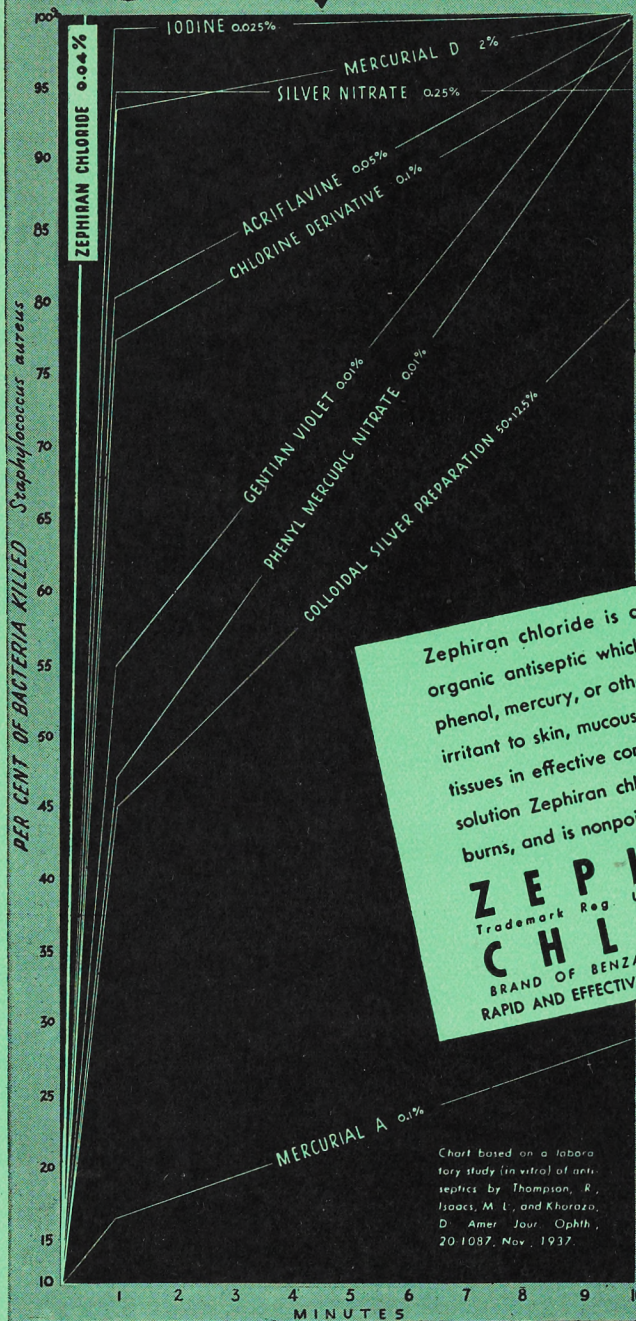
When the test as a whole is considered, the percentage of error is approximately 10%. In cases where a radiographic diagnosis of disease of the gall bladder was made the figure is reduced to 5% or less. Of those cases in which a clinical diagnosis of cholecystitis has been made but visualization was considered normal, between 20% and 30% were reported as showing evidence of gall bladder disease after removal and pathological examination.

The reliability of the test will naturally vary according to the care and skill with which it is done, but when carried out with a reasonable degree of caution it has proved of valuable assistance in the diagnosis of gall bladder disease.

A country doctor needs more brains to do his work passably than the fifty greatest industrialists in the world require.—Walter B. Pitkin.



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Zephiran chloride is a powerful, stable, organic antiseptic which contains no iodine, phenol, mercury, or other corrosives. It is non-irritant to skin, mucous membranes or wound tissues in effective concentrations. In aqueous solution Zephiran chloride neither stings nor burns, and is nonpoisonous.

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CHLORIDE  
BRAND OF BENZALKONIUM CHLORIDE REFINED  
RAPID AND EFFECTIVE ANTISEPSIS WITHOUT IRRITATION

AQUEOUS SOLUTION 1:1000, BOTTLES OF 8 OZ. AND 1 GALLON. STAINLESS TINCTURE 1:1000, BOTTLES OF 8 OZ. AND 1 GALLON. TINTED TINCTURE 1:1000, BOTTLES OF 8 OZ. AND 1 GALLON.

Chart based on a laboratory study (in vitro) of antiseptics by Thompson, R., Isaacs, M. L., and Khorazo, D. Amer Jour. Ophth., 20:1087, Nov., 1937.

WRITE FOR DETAILED LITERATURE



WINTHROP CHEMICAL COMPANY, INC., Pharmaceuticals of merit for the physician, NEW YORK 13, N. Y., WINDSOR, ONT.



## Something Old

### The Death of Socrates

The servant went in, and then returned with the jailer carrying the cup of poison. Socrates said: You, my good friend, who are experienced in these matters, shall give me directions how I am to proceed. The man answered: You have only to walk about until your legs are heavy, and then to lie down, and the poison will act. At the same time he handed the cup to Socrates, who in the easiest and gentlest manner, without the least fear or change of color or feature, looking at the man with all his eyes, took the cup. Then holding the cup to his lips, quite readily and cheerfully he drank off the poison. And hitherto most of us had been able to control our sorrow; but now when we saw him drinking, and saw too that he had finished the draught, we could no longer forbear, and in spite of myself my own tears were flowing fast; so that I covered my face and wept.

He walked about until, as he said, his legs began to fail, and then he lay on his back, according to the directions, and the man who gave him the poison now and then looked at his feet and legs; and after a while he pressed his foot hard and asked him if he could feel; and he said, no; and then his leg, and so upwards and upwards, and showed us that he was cold and stiff. And he felt them himself, and said: When the poison reaches the heart, that will be the end. He was beginning to grow cold about the groin, when he uncovered his face, for he had covered himself up, and said (they were his last words)—he said: Crito, I owe a cock to Asclepius; will you remember to pay the debt? The debt shall be paid, said Crito; is there anything else? There was no answer to this question; but in a minute or two a movement was heard, and the attendants uncovered him; his eyes were set, and Crito closed his eyes and mouth.

Plato: "Phaedro."

\* \* \*

### Visiting Speakers for the Annual Meeting September 25th, 26th, 27th

Dr. H. G. Pretty, Montreal.

Dr. L. Gerin-Lajoie, Montreal.

Dr. W. G. Crosby, Dr. John Hepburn, Dr. T. C. Routley, Toronto.

## Something New

**Severe and even fatal hemolytic** reactions may follow the transfusion of Rh + blood to Rh — women who have borne Rh + children because these women are permanently sensitised.

The Rh factor is not responsible for **habitual abortion**. Iso-immunisation does not occur prior to the sixth month. A series of patients with histories of repeated abortion were found to be Rh + in 88% and Rh — in 12%—the same proportion as in the general population.

**Meningitis** should be treated with penicillin only when the sulphonamides, after 48 hours of trial, have failed.

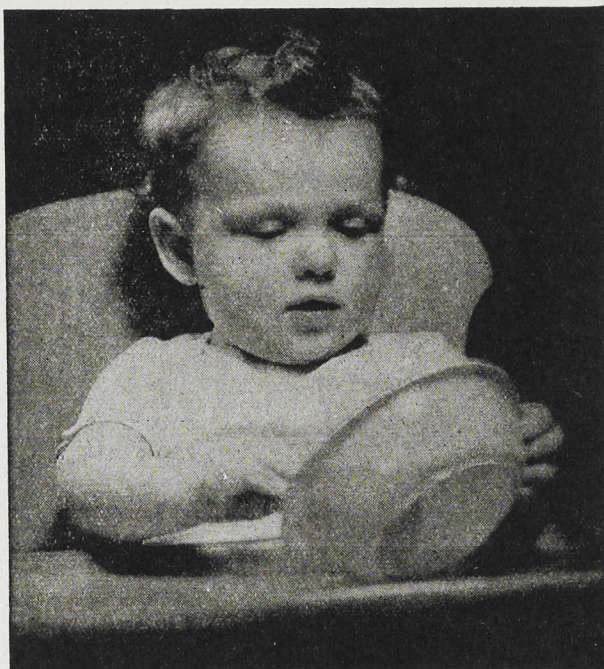
**Radiation** therapy begun as soon as signs of **mastitis** appear will prevent abscess formation. The dose varies with circumstances, and the full technique will be found in an article by Harvey, Spindler and Dowdy in Surg., Gynec. & Obst. 80: 396.

**Irradiation Sickness** can be prevented by thiamin chloride in doses of 6 to 9 mg. daily during the course of radiation. For active treatment pyridoxine hydrochloride has been given intravenously in doses of 25 mg. Benzedrine in small doses is prophylactic. Therapeutic dosage is 5 to 10 mg. three times daily.

The subjective symptoms of **inoperable cancer** of the female genitalia can be alleviated by the weekly administration of 140-150 mg. of testosterone propionate. This treatment has no effect on the growth.

Theophylline is valuable in cases of **severe heart failure, of severe angina, and of bronchial spasm**, whether the latter be allergic in origin. When given intravenously it must be given slowly, preferably by slow drip, 0.5 gram of drug in 200 c.c. of 10% glucose solution being given during the course of two hours.





# War Diets

OF  
LITTLE  
HELP  
IN  
PEDIATRICS

WHETHER rationing is more or less liberal, the pediatrician as always has the problem of supplying sufficient vitamins A and D to his young patients. Vitamin D in particular must be supplied abundantly to insure adequate structural development and calcium-phosphorus metabolism.

For this purpose Navitol\* with Viosterol offers these features:

1. It has an unusually high vitamin A and D content per gram—65,000 units of A—13,000 units of D.
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3. Cost per daily dose about one-half cent.
4. Highly palatable.

Navitol with Viosterol thus affords a convenient and economical means of supplying the fat-soluble vitamins A and D which every infant needs every day. Specify it for expectant mothers, infants, children, and patients requiring a vitamin A and D supplement.

Navitol with Viosterol conforms to the maximum vitamin A and D potencies of U. S. P. XII Concentrated Oleovitamin A and D.

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## Editorial

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J. C. Hossack, M.D., C.M. (Man.), Editor  
R. B. Mitchell, B.A., M.D., C.M. (Man.), F.R.C.P. (C), Associate Editor

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### The Convention

Con (together) and venire (to come) is the derivation of the word "convention." It is a coming together of those who wish to learn and those who wish to instruct; of those from the country and those from the city; of the East and the West; of old schoolmates long separated. To every doctor one or other of these facts is an incentive to turn his back for a while upon his patients and his face to where his fellows are gathering.

There will be opportunities to play as well as to work. There will also be, I doubt not, unofficial sessions where one can study non-anatomical osteology and where the flushes have nothing to do with the menopause. And any stranger who thinks of coming will promptly find himself absorbed into the family.

J. C. H.

♦

### The Review

I am an optimistic sort of person, young enough to see visions and old enough to dream dreams. The fact that I have a devil of a time trying to fill these pages does not prevent me from seeing a vision of a very large Review, or from dreaming of authors pressing many contributions upon me. The dream, perhaps, may never be realised, but there is no reason why the vision should not come true. We have on the Faculty of the Medical College over 120 teachers. Now, if each of these would contribute a single article during the course of twelve months we could have ten papers in each issue. And if each one of the 60 local internes would, during his or her whole year of service, prepare but one case report we could have fifteen useful contributions each month. These, together with our other features, would make a very excellent periodical.

Just think what the publication of a hundred-page Review would mean to Manitoba Medicine. Even as it is, the Review is finding favour in far places. Not long ago the Ulster Medical Society asked us to send it regularly. The other day the librarian of the College of Physicians of Philadelphia wrote, saying that he had had several requests for the Review, and would we put his library on our mailing list. Recently we had a communication from Cleveland and one from Mexico. Apparently what we have to say is of interest to doctors in Belfast, Philadelphia and other large and distant cities. Let us then say many useful things, so that our distant readers may the more enjoy our Review and the more appreciate our practice.

There is a little town in, I think, the State of Kansas, called Emporia. Very few people would know of it were it not for its newspaper, but the Emporia Gazette is world-famous. We are at an advantage, for there are few who are ignorant of our city and province. But we can, through our pages, make our school, our city, our province and ourselves better known throughout the medical world. After all, fate has made us the medical metropolis of the West—a position that carries with it not only prestige, but responsibilities.

If the Dean, at a meeting of the Faculty Council, were to ask all those who were willing to give a little time and go to a little trouble for the sake of the College to show their hands, I am sure that every hand would go up. I would like him to do this and then, when the hands are withdrawn, to say: "Then I expect each one of you to contribute at least one article each year to the Review." It would be such an easy promise to fulfil. Every teacher during each session gives many lectures or clinics, or both. These must be prepared. What more simple than to convert a lecture or a clinic into an article? Easier still would be the dictation of that material to a stenographer. Easiest of all would be the presence of a stenographer at the lecture or clinic in question. Then a few minutes of editing would put it in shape. I am sure that during the course of a year every teacher gives more than one talk that is as well suited to the needs of men in practice as it is to those of the undergraduates. And there are many in practice who would profit greatly from what one might call the simpler instructions in both academic and clinical subjects.

But can I privately and individually get the idea across? I can't. Resistance is terrific. One teacher who gives perfectly splendid clinics and presentations says, "I simply can't write." To another I say, "You give many clinics and lectures every year." And she answers me, "That's why I don't write." Another says, "I've given you one paper already. I don't want to be appearing all the time." To which I reply, "One paper a year isn't appearing all the time. Besides, if your paper was a useful one, you can depend upon it that our readers will be glad to see many more by you." Still another says that writing is just a form of advertising. Of course it is. But so is **not** writing a form of advertising. If one has useful knowledge that he can place at the disposal of his fellows, it is a duty and a privilege to do so. I think I'll apply for a diploma in



dentistry, for getting contributions is sometimes like pulling teeth—tough, old, glued-to-the-jaw teeth.

But not even these discouragements will banish the vision of a hundred-page Review. The Faculty should be the chief source of supply, but it is not our only source. There are many men and women practicing throughout the province who, if they would take the time, could tell us useful and interesting things. We want to hear from them. We would like contributions from other provinces. As soon as restrictions are lifted we hope to have the Review in the hands of every Manitoba graduate, wherever he may be; and we hope to be as well-known throughout the whole West as we are now in our own province.

Returning medical officers will be able to get their post-graduate instruction only in Canada. Neither the United Kingdom nor the United States will be able to take other than their own graduates. Manitoba, then, must measure up to a new responsibility. Some students will prefer to re-enter their own alma mater. Others may wish to study elsewhere. These may be attracted to this school by having read useful, thoughtful, practical papers in the Review.

"Without vision the people perish." I cannot say that failure of my own particular vision dooms our school to extinction; but I am very certain that its realisation would greatly help its work both within and without its walls.



### Portrait of a Pioneer Physician

#### Thomas Jasper Lamont

Thomas Jasper Lamont was born in 1858 near Walkerton, Ont., of Scottish ancestry. His grandfather was an early pioneer of Bruce County, coming to Canada in 1843 from Scotland.

He received his Teacher's Certificate from the Walkerton High School and came west to Manitoba in 1881. In February, 1882, he accepted the position and became the first teacher in Brandon, Manitoba. Mary Weightman, who later became his wife, was the second teacher.

Later he decided to study medicine and was in the fourth graduating class of the Manitoba Medical College, winning the Boyle Scholarship in Surgery—graduating in 1889.

The path of the student in search of an education was a hard one in those days, especially for one who was married and had three small children. During his course he taught a summer school near Treherne, Man., and fell in love with the beauty of the countryside. He admired the pioneers of that district.

On graduation he decided to return to Treherne and take up a country practice. He never regretted it. His was a wide field of service and his practice extended over many miles. He took an active interest in church, school, and community affairs. He was a man of great energy and exuberant vitality—a man of many friends.

Following the last war he was made an Honorary Captain by the French Government in appreciation for the services he had given gratuitously to the families of Frenchmen who had been recalled to fight in the Great War.

After 31 years of practice, when driving to visit a patient, he met with a fatal accident and died on October 5th, 1920.

It has been said of him "that to this man daily work was never merely a means of making a living, but a great opportunity for service." He devoted all his energy and talents to the care of his people—their welfare was always uppermost in his mind—he was generous to a fault—if their need was greater than his, he was always willing to share what he had. He died a comparatively poor man, but poor only as some judge success—for by his kindly deeds he was rich in friends.

At his funeral service Catholic, Protestant and unbeliever crowded the church to pay their last respects to the country doctor who was their friend, and who, when they were in trouble and needed help, came in fair weather or foul to their aid, and gave the best that he was capable of without thought of recompense.

After his death his work was carried on by his son until 1940, when he left the district to enlist in the R.C.A.F. This completed a period of 51 years' medical service to this community.



In memory of his father, a pioneer Manitoba physician, J. Laurie Lamont, M.B., Assistant Chief Medical Officer, Department of Veterans Affairs, Winnipeg, has donated to the University of Manitoba the sum of \$3,000.00, the proceeds of which are to be used to provide the Dr. T. J. Lamont Memorial Prize. The prize will be offered every alternate year for an essay or report on original work or investigation on maternal and neo-natal welfare. Competition is open to graduates in medicine of the University of Manitoba up to the end of the fifth graduate year. The winning essay will be published in a suitable Canadian medical journal. The donor hopes that the prize will not be regarded as a goal in itself, but rather as stimulus to improvement in maternal and neo-natal welfare.

### Manitoba Medical Centre

On June 22 a large deputation waited on Premier Stuart Garson, Hon. Ivan Schultz, Minister of Health and Public Welfare, and Hon. J. C. Dryden, Minister of Education, to support the plan of the proposed Manitoba Medical Centre with units grouped around the Medical College. Dr. P. H. T. Thorlakson presented a brief which set forth the aims and objects of the proposed centre and was supported by Dean of Medicine A. T. Mathers, President H. P. Armes, Dr. Bruce Chown and others. The Premier and his associates, received the representation with attentive courtesy and stated in closing that he and his colleagues were in sympathy with the plan of Manitoba Medical Centre, but that the resources of the government were not unlimited. It would be necessary, he said, to have a joint committee set up between the Manitoba government, the City of Winnipeg and the University of Manitoba to consider the relative proportion of costs. We are informed that the Manitoba government has appointed as its representatives to this committee Mr. R. McN. Pearson, of the Treasury Department, and Dr. F. W. Jackson, Deputy Minister of Health.

The brief read by Dr. Thorlakson and the remarks of Dr. Mathers, President Armes and Dr. Bruce Chown follow:

**Dr. Thorlakson:** Mr. Premier, this representative group, whom you see before you, would respectfully ask your approval and support to an undertaking of provincial importance—namely, the Manitoba Medical Centre. The Cities of Winnipeg and St. Boniface, the University of Manitoba, several hospitals, and many provincial organizations, are now committed to this enterprise. With the support of the Provincial Government, we are convinced that in the course of the next five or ten years there can be established in this province a University Medical Centre, which will occupy a unique position in the field of public service. This Medical Centre development cannot be viewed other than as a vital integral part of the policy and plans recently submitted by the Hon. Mr. Schultz to the people of this province. The opportunity which now presents itself of co-ordinating the efforts of our leading hospitals in this large philanthropic endeavour, should not be disregarded or allowed to pass for the want of immediate action. If the various hospitals concerned proceed as isolated units in their own development, the opportunity for centralization under a Medical Centre plan may never come to us again. This earnest conviction is based on three years of work and study. The groups represented here this morning are the strongest proof of our desire and determination to accomplish these plans.

We ask you, as Provincial Treasurer, to arrange a conference between the Treasury Department, the Department of Health and Public Welfare, the Finance Committee of the City Council, and the University of Manitoba to determine a fair and just proportion of financial responsibility for providing the hospital facilities for teaching and training and the care of the sick, so essential to the fulfillment of the plans and promises that have been made by your Government. No health and medical care programme for the people of Manitoba can be disassociated from the responsibility of teaching and training, nor from the responsibility of paying for it. At the present time, your University could not qualify and graduate doctors if it were not for the co-operation and generous assistance of private hospitals. The Province makes no financial contribution to these hospitals for the special teaching facilities of our University.

You will be interested to know that the statements made regarding our programme of development are in agreement with views expressed in a recent British report:

"Underlying our recommendations on undergraduate medical education is the conception of a university medical teaching centre, consisting of a university medical school, a group of teaching hospitals, and such clinics of the health services of the district surrounding the medical school as should be used for teaching purposes. This conception arises from our belief that, nowadays, the educational facilities and atmosphere required for the production of the type of doctor needed by the community can be obtained only by so interlocking the administration and work of a medical school and of the hospitals and health service, to which the school must have access, that they function as a unity in the tasks of education."

This report continues to say that, "All practical means should be sought to bring every hospital into association, directly or indirectly, with a medical teaching centre. The spirit of education must permeate the whole service." This British report came to hand only a few weeks ago, yet these quotations express the same objectives that have actuated the sponsors of the Manitoba plan now for three years.

One more quotation from this report will suffice to further illustrate the fact that the views and plans of the local committee are in accord with the trend of our time: "If medical education and research in Great Britain are to form a sound foundation for the national health service, the medical schools, post-graduate institutions and hospitals concerned will have to be given greatly increased financial support from public funds."



**Dr. Bruce Chown** said that the Children's Hospital was built in 1911 for a reason. It was the end of the last great migration, leaving conditions in North Winnipeg very bad. Disease and death were high among children in that district. That need no longer exists. The child popula-

tion has moved. Only one-third now live north of the C.P.R. tracks; the urban population is now greater in the west and south. Therefore, the Children's Hospital is badly placed.

Originally, the hospital was built to treat badly ill children, but it later became the main pediatric teaching unit, and for this reason, also, we are badly placed.

When a small hospital tries to treat all types of disease, a large consulting staff is necessary. Therefore, we must often call men from the Winnipeg General and St. Boniface Hospitals. That means delay and the prolonging of hospital care. That is another reason it would be desirable to have the Children's Hospital in a location close to the Medical School.

We have attempted to develop research facilities. In that respect, we have been far behind in Manitoba. We could do a better job in research if we were near the Medical College and other hospitals, for a co-ordinated effort is needed.



#### **Notice to Medical Practitioners re Firefighters' Medical Scheme**

The contract with the above group was terminated on June 30, 1945. The deadline for sending in medical accounts for this group has been fixed at August 30, 1945, so that the business can be finally and properly disposed of.

Members are reminded that this gives them sixty days in which to render accounts.

D. L. Scott, M.D.,

Secretary, Manitoba Medical Association.



#### **Papers for Scientific Session**

The Programme Committee of the Annual Meeting of the Manitoba Division of the Canadian Medical Association invites members of the Association to advise the Committee, at the earliest possible date, if they wish to present a paper at the Scientific Session.



#### **Which is More Important, the Man or the Job? Dr. A. Gibson**

A man aged 43, born in Iceland, came early to Manitoba. He worked on a farm and by the time he was 15 years of age he had reached grade 3. He was on a farm from 1910 to 1937. From 1937 to 1941 he was in a lumber camp. Some time in 1941 a tree fell on his shoulder, resulting in loss of movement in the upper limb. Pain was a prominent symptom following this accident. Some time later he had the thumb removed from the injured arm.

This man is married, has four children, and since his accident (1941) has earned \$322.00. He

was on an assembly line for four days and was dismissed because he could not keep up with normal individuals. It would appear that no employer wants him now.

There are two points on the above: (1) The worker's morale and the well being of his family and (2) the responsibility of the community.

This problem of rehabilitation, Dr. Gibson mentioned, is recognized in Great Britain, where a patient leaving either a civilian or military hospital is visited by an official of the Ministry of Labour. This official interviews the patient and usually the patient is given 28 days sick leave after leaving the hospital. At the end of this period the official from the Ministry of Labour has four alternatives for the convalescing patient: (1) Old job. (2) Any job that may come handy. (3) Those unable to do the old job, but capable of being trained for another occupation. (4) Unemployable. Before being put in any of these four categories the convalescing patient is examined by a Board of five men. This Board may recommend suitable training up to six months. Pay and allowances go to the convalescent patient during this period.

Dr. Gibson mentioned a splendid exhibition in London, England, showing the work of handicapped people. In Britain certain occupations are reserved for handicapped people. It would appear that industry must assume a quota of handicapped persons. Dr. Gibson mentioned rehabilitation of the blind operating simple machines. These simple machines did the work of one complex machine operated by a normal person. The speaker stated that blind people did excellent work without favor operating these simple machines.

Dr. D. J. Fraser, of the Workmen's Compensation Board, mentioned visiting the rehabilitation clinics in Ontario and British Columbia. Both these provinces have a large amount of industry; it was thought that Manitoba has not sufficient industry for the use of such a clinic.

Dr. Fraser reviewed the accidents of the Workmen's Compensation Board for 1942. There were 16,228 accidents: 265 of these had permanent disabilities; of these 265 a large number were under 10%. There were 78 over 10% of partial disabilities; of these 78, 34 are unemployed as yet. Of these 78 Dr. Fraser thought that 16 might benefit by a rehabilitation clinic.

Dr. Fraser pointed out the cost to employers of the total disability of a young man, in one instance total of \$26,500.

Peoria, Illinois, has an excellent rehabilitation centre. This is a community effort where industry, employers and community co-operate in its maintenance. Dr. Fraser was of the opinion that rehabilitation should be a community effort.





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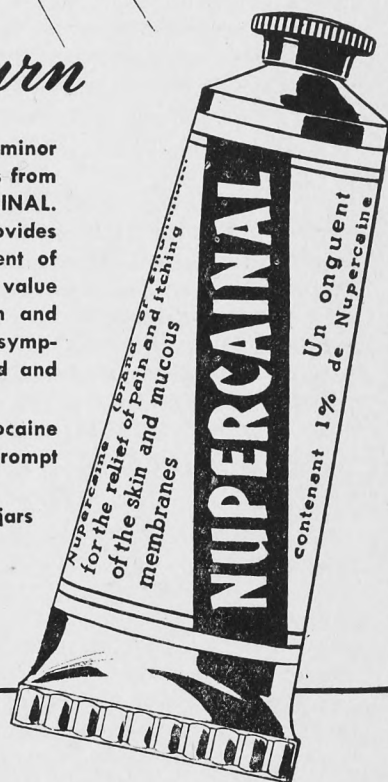
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TOMORROW'S MEDICINE FROM TO-DAY'S RESEARCH

## Manitoba Medical Service

A few words about the assessment of bills. These have in most cases to be based on information given on the report, and the reports frequently contain very little. It has been suggested that in cases of reduction, the doctor should be called and the matter discussed; if you appreciate that over twenty-two hundred reports a month have to be assessed, in a majority of cases missing details filled in for the permanent record, that each record is handled eight times to eliminate errors, and that we work against a time limit in order that you may receive your cheques within a reasonable period, you will understand that only a few cases can be so discussed, and for special reasons. You will have seen in the Manitoba Medical Review, that the Medical Director is now empowered to strike a fee for every type of service not listed. I do not suppose that there is any doctor on this continent capable of doing that without some inequities; the list recently provided by the C.M.A., giving the fee scale of every province, and then averaging them, is of great help; in cases where a procedure is not listed, I call up two or three doctors who do the same type of work, and average the figures they give me. No names are mentioned. In many cases of reduced bills the doctor has apparently never looked at the fee schedule provided by the Executive Committee of the Manitoba Medical Association.

Equitable distribution of funds available has been one of our great difficulties, even though we have received much assistance from lay members of our Board, who have considerable financial, statistical and actuarial experience. All bills up to June 1st were assessed, as you know, \$1.00 to \$10.00, 100%; \$10.01 to \$20.00 were paid \$10.00, and bills of \$20.01 and over, 50%. Under this method, doctors giving a large number of minor services received in some cases 90% of their approved bills; while those giving a few major services received not much more than 50%. A new method drawn up by an actuary, and put into operation for your June accounts, was as follows. Up to \$4.00, 100%; \$4.01 to \$10.00, 75%; \$10.01 to \$50.00, 60%; over \$50.00, 50%. Instead of averaging 65% payment of approved bills of \$24,500.00, it cost us 73%, and exceeded by a considerable sum our revenue. The Finance Committee, who insist that we must work within our present income, have revised the basis of payment. Payment of July accounts, as recommended by the Finance Committee, and approved by the Board of Trustees, is as follows: Up to \$4.00, 100%; any amount over and above \$4.00, 50%. If there

are any doctors with financial ability who care to submit a plan, we shall be very happy to consider it; but we would recommend that you first of all come to our office and see what the administrative and other problems are, before putting it on paper.

Rulings have been obtained from legal counsel as follows:

### Anaesthetic Services

Of the two plans, A and B, the latter makes no reference to anaesthetics or anaesthetists.

Plan A provides that surgical services shall include the fee, not exceeding \$10.00, of an anaesthetist in emergency cases occurring between 2.30 p.m. and 7 a.m., if no salaried anaesthetist is available.

The M.M.S. can, therefore, only pay the fee of an anaesthetist if it comes within this last quoted provision, and then only to the extent of \$10.00. No other fees of anaesthetists can be paid by the M.M.S.

### Payments to Non-Members

In cases of emergency when it is necessary for the subscriber to obtain surgical services from a duly qualified medical practitioner who is not a member of the Association, the Association will pay such practitioners for such services at the rate payable to medical members as set out in Table A as from time to time in force for the same services. Should any dispute arise as to whether any such occasion is in fact a case of emergency, such dispute shall be referred to a special Board of three referees to be appointed by the said Board of Trustees and the decision of the said referees or a majority of them shall be final and binding both upon the subscriber and the Association.

The Manitoba Medical Service must strictly adhere to the rule that except in these special cases it cannot pay accounts of medical practitioners who are not members of the Manitoba Medical Service.

The Board of Trustees has been considering the scale of fees for diagnostic investigations. Conditions not anticipated by the Executive Committee of the Manitoba Medical Association have arisen, and a letter has been written asking for a revision of them. They were drawn up on the supposition that the doctor would be doing them, but he rarely does; also that they would be used to the same moderate extent as they had been in the past when patients had to pay for them, along with a large bill for medical or surgical



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services. If a revision cannot be obtained the only other method is to assess these services at a certain percentage of all claims, in order to preserve a proper balance, thus reducing the payment to a figure which can be met by a percentage of revenue to be agreed upon.

For a period of two years or more, criticisms of the Manitoba Hospital Service Association have been made by members of the medical profession as follows: Citizens who used to be admitted as public ward patients and accepted for free treatment, have for that period entered hospitals as semi-private patients but were unable to pay the doctor for his services. This situation has been altered to a considerable extent by the operation of the Manitoba Medical Service. We are anxious to know to what extent you have noticed the change, in that you get paid for work for which you formerly received little or nothing. If you cannot give figures, give an estimate, considerable, little or no change, put it on paper and mail it to me or telephone our Administrative Department at 92 181.

### Illegibility

Sometimes even your own nurse-secretary, when appealed to, cannot decipher your handwriting for us. If she cannot, please let her tell you so before sending in the report.

If it will save you time a rubber stamp replica of your signature **with your code number** will be quite acceptable to this office. It will help this office and yours considerably if you would forward reports on short term cases as soon as the service is complete, instead of waiting until the end of the month.

Enrolment of members as at June 30th was 17,464, an increase of 2,680 since May 31st. B plan is still the more popular and has 85% of the membership; should bad times come, it is possible that many would drop the B plan, but still protect themselves from surgical emergencies through the A plan.

A. G. RICHARDSON,  
 Manager.

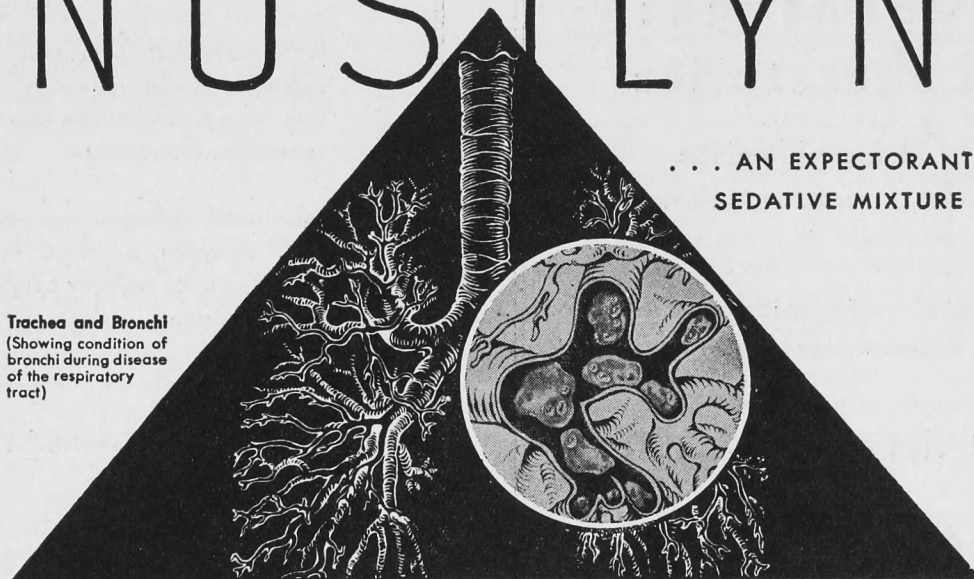
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ful (60 drops) diluted to one teaspoonful of water,  
and taken every four hours.



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## Book Reviews

### Patients Have Families

**Patients Have Families.** By Henry B. Richardson, Associate Professor of Clinical Medicine, Cornell University Medical College; Attending Physician, New York Hospital; Visiting Physician, Bellevue Hospital. 408 pages. The Commonwealth Fund. New York. 1945. In the United States, \$3.00.

Patients have families and not seldom the family supplies the cause and sets the pattern of a patient's illness. When we realise that the family is the social and economic unit it is not difficult to see in it also the unit of health. That is now the accepted practice of health agencies and organisations. Certainly nothing so influences a person as does his family. Indeed the family is almost as much a part of the individual as the individual is part of the family. It is in the family that emotional and cultural patterns are designed and woven; and these patterns influence the development and form of sickness.

We are drawing away rather rapidly from the older concepts of disease—that all physiological disturbances were organic in origin and that all psychical disturbances were varieties of insanity. Now we realise that disturbances of function may occur in organs structurally sound and that the psyche can express disharmony in less overt ways than by the extravagances of madness. The realisation that body and mind cannot be separated has led to greater interest in the patient as an individual. Now we are becoming increasingly aware of the fact that we can completely understand the patient only when we consider him in his relationship to his domestic circle. We must, indeed, know something of both his families if to that of childhood he has added that of marriage. Just as the naturalist studies the lower animals in their natural habitats, so must we study man in his.

The more one studies sickness from the standpoint of the patient as an individual the more interesting become both the sickness and the patient; and extending the scope of investigation to include the family heightens the interest in all three elements. We are moved to ask why it is that certain disorders seem to "run in families." Does the secret of their obscure etiology lie in physical make-up or in common psychical stresses or is the illness "copied" in some way by different members of the family? The only way to discover the role played by the family in disease is to study many families in the various aspects of their living. Such a study was undertaken by a group under the leadership of Dr. Henry B. Richardson of Cornell University Medical College. Associated with him were psychia-

trists and social workers. The report of this committee takes the form of a 400 page book "published for the purpose of presenting (a) the value to the medical profession of seeing the individual patient as a personality and as a part of his family constellation, and (b) the essential contribution which can be made by psychiatry and the 'social disciplines' (i.e. professions) to this view of the patient."

Fifteen families in all were studied and the report deals in extenso with twelve of these. As we read we become familiar with the stresses, emotions, reactions, ailments and difficulties of each individual and of the whole group. We can see very clearly the influence of the individual upon the group and of the group upon the individual and the reflection of these influences in the patterns of health or sickness. As we study the unfolding story of each person it is borne upon us that little progress would have been made had the individual been considered merely as such, just as no progress had been made when treatment had been directed upon an offending or supposedly offending organ. Yet when the patient is treated in his larger self—the family—and when the problem is attacked as in a combined operation by workers in several fields the results are in the highest degree heartening.

Dr. Richardson divides his book into three parts, the first of which he entitles "The Family as the Unit of Illness." He gives the separate unconnected stories of each member of a family as recorded at their visits to the clinic, before they were studied as a group. The data then given take on a new significance when the separate tales are woven into one. Next we are given the views of investigators who look at the family and its members from the standpoint of their own subjects—psychiatry, family social work, medical social work. These workers enable us to view the case with, as it were, stereoscopic vision. We learn about the development of these individual personalities, can appreciate their mutual inter-reactions and can understand the basic mechanisms of the sicknesses for which they sought relief.

The last two chapters in the first part of the book deal with family equilibrium. Individuals and families alike seek to establish and maintain themselves in a state of balance between their internal and external environment. This is an application to the family of Cannon's concept of homeostasis. Normal health is the result of the component parts of the body being balanced among themselves. "The members of the family may be compared to the organs of the body, in spite of obvious differences (and) each individual



is profoundly affected by the others." Dr. Richardson then goes on to tell how the dynamic equilibrium of the family is set up and its functional integrity threatened and maintained. The roles played by dominance, identification, cultures, motivations and so on are illustrated in the persons of patients who, by now, are familiar to us in their domestic setting.

Part Two of "Patients Have Families" is entitled "The Family as the Unit of Treatment." The first chapter is devoted to the general practitioner who "knew the skeletons in the closet for thirty miles around and kept his own counsel." As time went on he gathered an enormous store of intimate knowledge of the community and thought in terms of the family and its welfare. The entry and development of specialisation improved the skillful care of the patient but brought an end to the practitioner who was, in the fullest sense, the "family" doctor. Stress came more and more to be laid on organisms and organs and less and less upon the host of the one and the possessor of the other. The splitting of medical omniscience among many doctors has left the patient without anyone who is much interested in himself, certainly without anyone who is intimately familiar with his domestic circle and relationships. But the importance of understanding the individual and the group is so great that something must be done to bring this into the orbit of medical concern.

This is the responsibility of the physician but circumstances are such that he cannot do it alone. His principal assistants must be the psychiatrist, the case worker, the medical social worker and the public health nurse. To all of these the family is already the unit so that the physician alone requires reorientation. And as health services in the future are more and more likely to be government-directed, the new viewpoint will come to be regarded as the normal one. The type of service that can be given by each of these auxiliaries and the value of that service is illustrated in the records of the families discussed.

There is collaboration of all investigators in every case but often the chief remedial procedure is almost exclusively within the field of a single worker, as when a social case worker straightens out an economic tangle or a medical social worker (more accessible than the doctor) can persuade the patient to follow the instructions that would otherwise be disregarded.

Part Three considers the Present and Future. A chapter is devoted to the Family in Wartime and another to the Family Unit in Hospital Practice and Medical School Teaching. Various ways are suggested for making the student conscious of the family unit. The last chapter deals with the Family Unit in Research. There are three

appendices, one of which gives a number of examples of "professional techniques". These include the reports of case workers and show how much useful data can be gathered by the social "disciplines".

Now that governmental agencies are taking so large a part in the management of health and sickness it goes without saying that their viewpoint of the family as the unit will ultimately be adopted by the medical profession just as it is now accepted by those other professions to which sickness in the family is merely a disturbance in the unit. "Patients Have Families", then, is a text-book of the practice to come. Its value in our present form of practice can be given in Dr. Richardson's own words: "Once the doctor gets into the habit of thinking about the family, he inevitably becomes clearer in his concept of illness even in the individual. Many apparently unrelated items fall into place like the pieces of a jig-saw puzzle; diagnoses otherwise obscure often become obvious and the problem of treatment, although complex in detail, becomes clarified in principle." "The benefits of such an approach are not limited to remedial medicine, but promise an increased efficiency in the prevention of disease . . . It is clear that whenever the family is recognised as the unit of practice, the distinction between remedial and preventive medicine disappears."

"Patients Have Families" is a well written and exceedingly interesting book which deserves a wide circle of readers.

J. C. H.

#### Technical Methods for the Technician

Technical Methods for the Technician. Third Edition. By Anson Lee Brown, A.B., M.D., Director of Dr. Brown's Clinical Laboratory and Dr. Brown's School for Technicians. Columbus, Ohio. Published by the Author. 1944. Price (in U.S.A.) \$10.00.

This is a handsome volume of 706 pages containing 229 black-and-white illustrations and 9 plates in colour. The introduction is devoted to "Laboratory Behaviour" and then follows a description of the structure and use of the microscope. Instructions are then given on the conduct of simple laboratory operations, such as the handling of reagents, heating of liquids, cleaning of glassware and so on. Part Three deals with urinalysis. No fewer than thirty tests are given for the detection of albumen. One feels that several of these could usefully have been omitted or replaced by tests for renal function none of which are mentioned except the phenolsulphophthalein test. Almost half the book is devoted to examinations of the blood. Nine colour plates, all

diagrammatic, are introduced to make more easy the recognition of individual types of cells. All the usual and some of the less usual tests are described for the determination of the various chemical constituents of the blood. Of serological tests for the presence of syphilis eight are given, including one original with the author. Agglutination tests are described but strangely no mention is made of paratyphoid fever. There is no reference to the Rh Factor. Three liver function tests are given—bromsulphhalein, Takata-Ara, and Rose Bengal—but the very useful hippuric acid test and the cephalin flocculation test are both omitted. Under the heading of miscellaneous tests are included pregnancy tests, smears, gastric analysis, sputum, feces, basal metabolism, spinal fluid and others. There is also a section on tissues, many tables and a list of works of reference. At the end of each section is a list of questions

The text is highly synopsised, each piece of apparatus, each reagent, each method, each step in each method gets a line to itself. This makes it exceedingly easy for the technician to follow. Nothing is said about the rationale of the tests or of the significance of the reactions. In other words, the book is devoid of theory. For those, however, who have gathered that knowledge from other sources and wish merely a book which will give them in the most succinct form the ways to perform these tests, Dr. Brown's book will be very useful.

#### Exercises in Human Physiology

Exercises in Human Physiology (preparatory to Clinical Work). By Sir Thomas Lewis, C.B.E., F.R.S., etc., 103 pages with 6 figures. Macmillan and Co., 1945. \$1.10.

"For many years," says the author in his preface, "I have held the view that the transition from preclinical to clinical studies is the most difficult period through which medical students have to pass." This period, he feels, can be made less difficult if the academically trained student is led by a familiar road to the unfamiliar environment of the bedside. "The desirable bridge has seemed to me to be the bridge of physiology." This little book is that bridge. Most of the exercises are concerned with the vascular system and the skin. The first group deals with visible vascular pulsation in the arms, the neck, about the heart and in the epigastrium. The student is told what to do and then is told the significance of what he sees or feels. The section concludes with the clinical application of this knowledge. Other groups of exercises concern the blood pressure; the relationship of blood pressure, respira-

tion and pulse; venous pressure; carotid sinus pressure; the X-ray and cardiographic examination of the heart; capillary contraction and pulsation; cutaneous sensation; skin pain, deep pain and pain from muscles working with deficient blood supply. These are but a few of the exercises. There is a section on pharmacological exercises in the performance of which the student experiences in his own person the actions of pilocarpine, amyl nitrite, atropine, histamine, adrenalin, etc. The purpose throughout the book is to impress upon the student the clinical value of a knowledge of physiology and the physiological basis of signs and symptoms.

Many of these exercises could usefully be performed in classes on physical diagnosis. Selected ones could be even more usefully employed to give point to a bedside clinic. Most students when they enter the clinical years are very familiar with physiology; it is a language which they understand, and when addressed in it by the clinician, their learning of the new language of the bedside becomes easier and the efforts of their teacher are more fruitful.

#### Eighteenth Anniversary Issue of the Hebrew

Volume I, 1945, eighteenth anniversary issue of the "Harofe Haivri" (The Hebrew Medical Journal), edited by Moses Einhorn, M.D., has just made its appearance. This special issue is dedicated to the late Henrietta Szold, a distinguished humanist and Zionist, who organised American Jewish womanhood in the great organization, Hadassah. This organization is responsible for a vast network of medical and sanitary installations in Palestine, which make it the outstanding health center of the whole of the Middle East.

Mrs. Rose G. Jacobs presents a very interesting article entitled "Henrietta Szold's Contribution to the Health of the Body and Soul of Palestine"; Mrs. Tamar De Sola Pool gives a detailed account of the life and work of Miss Szold.

Dr. S. R. Kagan contributes an article on the contribution of the pioneer physicians to the growth and development of the Zionist movement throughout the world.

There is also a detailed English section containing summaries and translations of all the articles for those readers who do not understand Hebrew.

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—Keith Preston.





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## Personal Notes and Social News

Major F. G. Stuart, R.C.A.M.C., eldest son of Mr. and Mrs. F. A. Stuart, of Moose Jaw, Sask., was married on Saturday, July 7th, to former Nursing Sister Beatrice Eileen Duggan, only daughter of Mr. and Mrs. W. P. Duggan, of Winnipeg.

Captain Morton E. Hall, Jr., R.C.A.M.C., recently returned from overseas service, was married at Hart House, Toronto, on July 21st, to Jessie Margaret Malcolmson, only daughter of Mrs. Geo. A. Malcolmson and the late Mr. Malcolmson.

Dr. and Mrs. D. C. Aikenhead's daughter Helen Lawrence was married on June 23rd, at Dominion United Church, Ottawa, to Kenneth Buckley, son of Mrs. Helen Buckley, of Saskatoon, Sask.

Major S. Jauvoish, recently returned from almost five years active service with the R.C.A.M.C. overseas, has resumed civil practice with offices at 206 Boyd Building.

Wing Commander and Mrs. Gilbert Adamson with their children have returned to Winnipeg from Ottawa, where they have spent the last few years. They are occupying their home, 159 Harvard Ave.

Captain F. N. Sparling, R.C.A.M.C. (Overseas), has been promoted to the rank of Major.

Dr. and Mrs. Wettlaufer of Fort San, Sask., are happy to announce the birth of a son (Robert John) at the Winnipeg General Hospital on July 10th, 1945.

Major Lawrence R. Rabson, R.C.A.M.C., was married at Aldershot, England, on June 7th to Lieut. Nursing Sister Elizabeth A. Hodge, younger daughter of Mr. and Mrs. John Hodge, of Victoria, B.C.

Dr. Edison R. Cunningham and his wife, Dr. Gladys Storey Cunningham, have sailed from Bombay, India, on the SS. Gripsholm, and are expected to arrive in Canada early in August.

Lieut. Donald D. McPhail, R.C.A.M.C., son of Dr. and Mrs. H. P. McPhail, of Manitou, Man., was married on July 16th to Lieut. Ethel Margaret Herriot, R.C.A.M.C., daughter of Mr. and Mrs. G. H. Herriot of Winnipeg.

Lieut.-Colonel Ross H. Cooper, who recently returned from overseas after five and a half years service with the R.C.A.M.C., is now in civil practice with offices at 212 Medical Arts Building.

Acting Major J. R. Matas, R.C.A.M.C. overseas, has been mentioned in dispatches for gallantry during service with the British army in Burma.

Dr. Jutta Brokovski, wife of Captain Theodore Brokovski, R.C.A.M.C., recently arrived in Winnipeg from overseas.

Dr. Leonora Hawirko, recently of Edmonton, Alta., is now practicing in Winnipeg, with offices at 514 Somerset Building.

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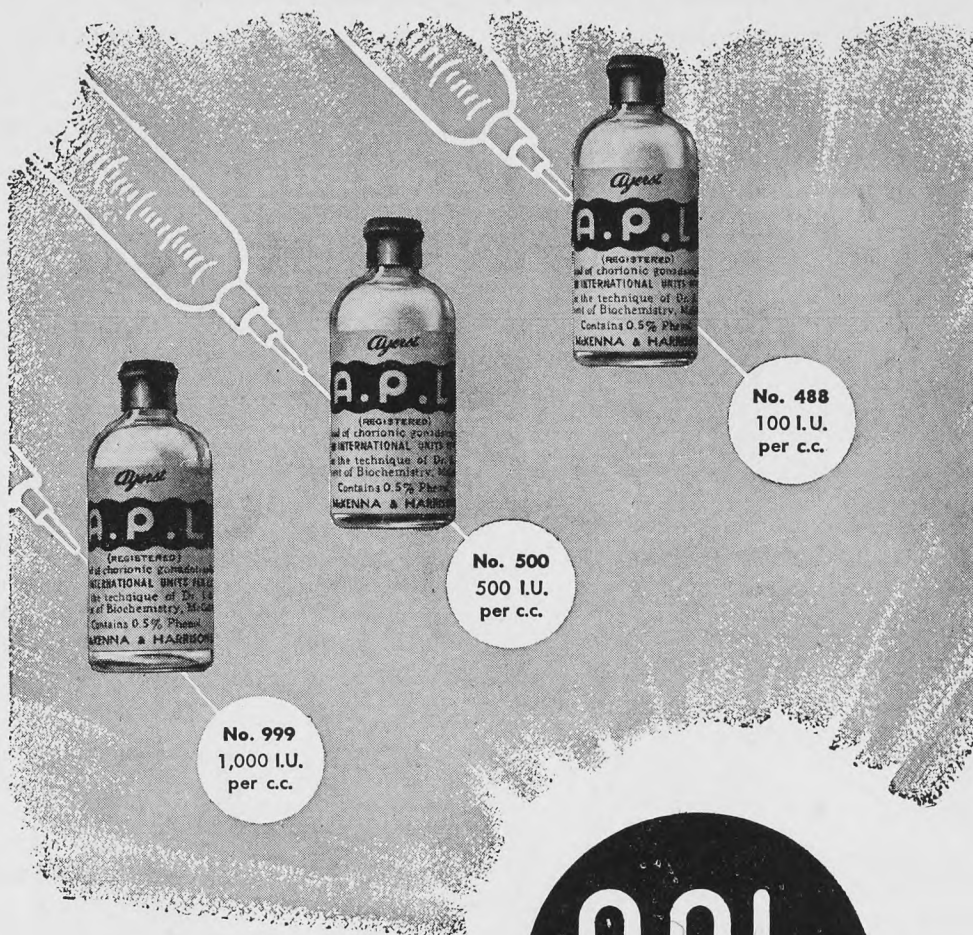
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## Department of Health and Public Welfare

### Comparisons Communicable Diseases — Manitoba (Whites and Indians)

DISEASES	1945		1944		TOTALS	
	May 20 to June 16	Apr. 22 to May 19	May 21 to June 17	Apr. 23 to May 20	Jan. 1 to June 16, '45	Jan. 1 to June 17, '44
Anterior Poliomyelitis	1	3	2	1	8	4
Chickenpox	207	209	184	134	1268	1395
Diphtheria	12	11	27	8	155	81
Diphtheria Carriers	1	1	3	1	22	18
Dysentery—Amoebic	—	—	—	—	—	—
Dysentery—Bacillary	0	0	2	1	1	3
Erysipelas	2	1	1	11	29	43
Encephalitis	1	1	1	1	4	4
Influenza	7	17	13	16	100	196
Measles	123	80	806	1420	432	4676
Measles—German	11	6	20	35	28	224
Meningococcal Meningitis	2	0	4	2	10	17
Mumps	181	157	82	157	994	1376
Ophthalmia Neonatorum	—	—	—	—	—	—
Pneumonia—Lobar	6	9	16	18	57	129
Puerperal Fever	0	0	1	0	0	4
Scarlet Fever	54	45	160	252	400	1619
Septic Sore Throat	3	2	4	2	12	21
Smallpox	—	—	—	—	—	—
Tetanus	0	0	0	1	0	1
Trachoma	—	—	—	—	—	—
Tuberculosis	71	70	91	57	304	325
Typhoid Fever	1	0	2	12	26	41
Typhoid Paratyphoid	1	0	0	0	3	0
Typhoid Carriers	0	0	0	0	2	0
Undulant Fever	0	1	2	1	5	4
Whooping Cough	13	19	43	24	188	196
Gonorrhoea	192	114	132	144	854	813
Syphilis	42	30	52	44	280	296
Actinomycosis	0	0	0	0	0	2

### DEATHS FROM COMMUNICABLE DISEASES

April, 1945

DISEASES (white cases only)	*726,000 Manitoba	*3,825,000 Ontario	*906,000 Saskatchewan	*2,972,300 Minnesota	*641,925 North Dakota
Anterior Poliomyelitis	1	2	—	—	—
Chickenpox	207	1,338	96	—	45
Diphtheria	12	7	1	8	5
Diphtheria Carriers	1	—	4	—	—
Dysentery—Amoebic	—	—	—	7	—
Dysentery—Bacillary	—	—	—	1	—
Encephalitis	—	—	—	—	—
Erysipelas	2	2	2	—	—
Influenza	5	186	—	4	14
Jaundice—Infectious	—	3	17	—	—
Leth. Encephalitis	—	1	—	—	2
Malaria	—	1	—	—	1
Measles	121	775	176	65	8
Measles—German	11	238	23	—	—
Meningococcal Meningitis	2	8	2	6	1
Mumps	177	561	102	—	—
Ophthalmia Neonatorum	—	—	—	—	—
Puerperal Fever	—	—	—	—	—
Scarlet Fever	54	311	24	315	78
Septic Sore Throat	3	19	14	—	—
Smallpox	—	—	—	1	—
Trachoma	—	—	1	—	—
Tuberculosis	62	450	40	15	37
Typhoid Fever	1	3	1	—	2
Typhoid Paratyphoid	1	1	1	—	—
Undulant Fever	—	5	—	18	2
Whooping Cough	13	121	11	40	5
Gonorrhoea	192	536	—	—	34
Syphilis	4	328	—	—	10

\*Approximate Populations.

**Urban**—Cancer, 44; Pneumonia (other forms), 9; Pneumonia Lobar, 7; Tuberculosis, 7; Syphilis, 5; Influenza, 2; Diphtheria, 1; Hodgkin's Disease, 1; Lethargic encephalitis, 1. Other deaths under 1 year, 17. Other deaths over 1 year, 179. Stillbirths, 19. Total, 292.

**Rural**—Cancer, 27; Tuberculosis, 17; Pneumonia (other forms), 14; Pneumonia Lobar, 6; Diphtheria, 2; Influenza, 2; Syphilis, 2; Typhoid Fever, 1; Dysentery, 1. Other deaths under 1 year, 18. Other deaths over 1 year, 154. Stillbirths, 14. Total, 258.

**Indians**—Pneumonia (other forms), 2\*; Tuberculosis, 2\*. Other deaths under 1 year, 1. Other deaths over 1 year, 1. Stillbirths, 0. Total, 6.

\*White on Indian Reserve.

Morbidity statistics for this four-week period show little out of the ordinary trend.

**Diphtheria**, with 12 cases reported in Manitoba is too common for this season and the total cases to date for 1945 are nearly double the number in the same period in 1944. This disease is of a virulent type and three deaths have been reported in the week ending July 7th. Everyone should be protected by toxoid.

**Puerperal Fever**—Not one case has been reported in Manitoba so far this year. Long may this continue.

By the time this copy of the Review reaches your desk "fly time" will also be upon us. Flies spread poliomyelitis, typhoid fever, dysentery and many other diseases. This should be kept in mind and every effort made to encourage the suppression of this insect pest.



### Canadian Amateur Photography Awards

"One of the outstanding exhibits of Canadian amateur photography that I have seen."

These were the words of Mr. Raymond Caron, A.R.P.S., A.P.S.A., one of the judges at the recent Canadian Physicians' Camera Salon held at the Eaton Art Galleries in conjunction with the Canadian Medical Convention.

This exhibit, the first of what is hoped will become an annual show, was held under the auspices of the Montreal Camera Club, and was sponsored by Frank W. Horner Limited.

The exhibition was formally opened at 10.00 a.m., June 11th, by Dr. Fred. J. Tees, P.S.A. Judges were Dr. Tees, Mr. Caron and Mr. F. T. Clayton.

Organized to give Canadian Physicians an opportunity to display their photographic talents, the exhibition was divided into two classes—one for physicians—the other for laymen. Each class was divided into two groups, Prints and Kodachrome—feature being that the exhibit was the second time that Kodachrome has been exhibited in Canada.

Winners in each group are as follows:

For Prints in the Physicians' Class—First, Dr. G. B. White, Port Colborne, Ont., "A Gallant Company;" Second, Dr. H. Campbell Brown, Vernon, B.C., "China Missionary;" Third, Dr. Claude Lamarche, St. Therese, P.Q., "La Cabane;" Honourable Mentions: Dr. W. K. Blair, Oshawa, Ont., "Snow and Mist;" Dr. L. J. Notkin, Montreal, P.Q., "Within Thy Portals;" Dr. G. B. White, Port Colborne, Ont., "Decorations by King Winter."

For Prints in the Laymen's Class—First, Dr. L. G. Saunders, Saskatoon, Sask., "White Winter;" Second, Hugh W. Frith, Vancouver, B.C., "Apache;" Third, J. Fraser Byrne, Toronto, Ont., "Putting Out;" Honourable Mentions: F. C. Houghton, Montreal, P.Q., "Dahlias;" W. D. Jewette, Woodlands, P.Q., "Youth Steps Out;" Dr. L. G. Saunders, Saskatoon, Sask., "Sleepy Little Spruce."

Of special interest was the colour photographic section, the second time in Canada that colour slides have been shown.

Colour Transparencies—in the Physicians Class—First Prize, Dr. Harvey Agnew, Toronto, Ont., "Peggy's Cove, N.S.;" Second Prize, Dr. R. Coyle, Windsor, Ont., "The Bow River Valley;" Third Prize, Dr. E. J. Trow, Toronto, Ont., "Clear and Cold."

Large crowds attended the exhibition daily and all expressed the hope that this would be just the beginning of such amateur photographic exhibitions.

## MANITOBA MEDICAL ASSOCIATION

*Canadian Medical Association, Manitoba Division*

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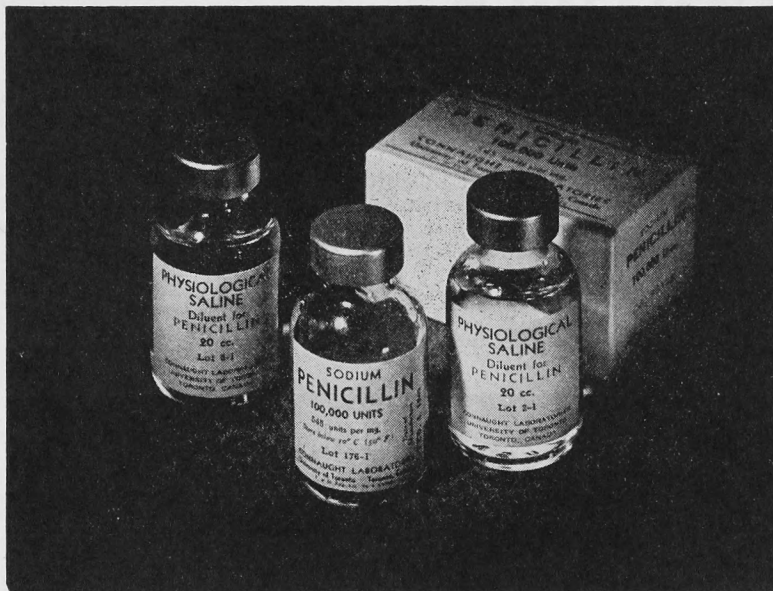
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